

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/26/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155677		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 09/13/2011	
NAME OF PROVIDER OR SUPPLIER BELL TRACE HEALTH AND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 725 BELL TRACE CIR BLOOMINGTON, IN 47408			
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F0000	<p>This visit was for the Post Survey Revisit to the Recertification and State Licensure survey completed on 7/27/11.</p> <p>Survey date: September 13, 2011</p> <p>Facility number: 002574 Provider number: 155677 AIM number: N/A</p> <p>Survey team: Melinda Lewis, RN, TC Marla Potts, RN Sharon Whiteman, RN</p> <p>Census bed type: SNF: 67 Total: 67</p> <p>Census payor type: Medicare: 26 Other: 41 Total: 67</p> <p>Sample: 9</p> <p>This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 14, 2011 by Bev Faulkner, RN</p>			F0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0314 SS=G	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident at risk of pressure ulcer did not develop pressure ulcers, in that Resident #100 developed 2 unstageable pressure ulcers in the facility, for 1 of 3 residents reviewed for pressure ulcers in the sample of 9.</p> <p>Resident # 100</p> <p>Findings include</p> <p>On 9/13/11 at 10:30 A.M., the Wound Nurse was observed to remove a gauze dressing from Resident # 100's right ankle/foot area. There was a pea-sized black area noted on the right outer ankle. There was a baseball-sized black area on the right heel. There was a black area noted to be the size of a deck of cards on the calf of the right leg. During this observation, Resident # 100's daughter indicated there was a red area on Resident # 100's right hip yesterday.</p>			F0314	<p>This plan of correction is to serve as Bell Trace Health and Living Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Bell Trace Health and Living Center or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. F 314 483.25(C) TREATMENT/SERVICES TO PREVENT/HEAL PRESSURE SORES I. Resident #100 has had the splint discontinued and is receiving appropriate preventative care and treatment. There is evidence on the weekly wound assessments that the wound is healing. The wound nurse received education regarding timely observation of any new skin issue. II. All residents at</p>		09/23/2011

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	<p>In an interview with the Wound Nurse, on 9/13/11 at 10:30 A.M., she indicated Resident #100 had been restless while in his wheelchair. She indicated Resident # 100 had placed foot over the pedal of the wheelchair hitting the heel on the floor causing the area to the right heel. She indicated Resident # 100 was up in wheelchair most of time to prevent him from getting pneumonia. She indicated when staff became aware of this Resident # 100 was changed from a wheelchair with the an elevated leg rest to a Broda chair. The Wound Nurse indicated the resident's skin broke down very rapidly and in a matter of days would go from a red area to a large area covered in eschar. The Wound Nurse indicated she had not been informed of the red area to Resident # 100's hip by staff nor had she received any documentation concerning an area to the hip.</p> <p>On 9/13/11 at 12:45 P.M., in an interview with the Wound Nurse she indicated she had not looked at Resident # 100's right hip. She stated other staff members were working with the resident and she had not yet had time to observe the hip.</p> <p>On 9/13/11 at 3:00 P.M., in an interview with the Director of Nursing and the Wound Nurse, the Wound Nurse indicated</p>				<p>risk for pressures sores have been identified, a plan of care has been written for prevention of skin breakdown and appropriate interventions have been implemented. In addition, a facility wide skin sweep has been conducted and any concerns addressed. III. A systemic change includes:</p> <p>C.N.A.s will visualize the skin of all residents daily during their am care and alert the nurse to any concerns. Any new area of concern regarding the skin will be alerted to the Unit Manager or designee for immediate intervention and the new intervention will be immediately communicated to the C.N.A.s and implemented. All new admissions, residents with a new immobilizer type device or residents with new skin conditions will be reviewed at the daily (Monday through Friday) clinical meeting. In addition, new admissions, residents with immobilizer type devices, residents with a decline and residents with a new skin area will be reviewed weekly at the facility's At Risk Meeting for the need for new interventions, until stable. All residents with an immobilizer type device will have skin checks below the immobilizer every shift or as allowed by the physician. Charge nurses will conduct rounds with the C.N.A. every shift</p>		

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	<p>she had observed the hip and there was a nonblanchable red area. She stated there had been no documentation in the resident's record. The Director of Nursing stated she had spoken with Resident # 100's daughter and was informed the daughter had assisted a CNA with Resident # 100's care on 9/12/11 when the area was observed on the right hip. The Director of Nursing indicated the area had not been reported to a nurse for assessment until the daughter informed the Wound Nurse on 9/13/11 at 10:30 A.M.</p> <p>The clinical record for Resident # 100 was reviewed on 9/13/11 at 10:00 A.M. The record indicated Resident # 100 had diagnoses that included but were not limited to right nondisplaced femur fracture and dementia. The MDS [Minimum Data Set] assessment, dated 8/2/11, indicated Resident # 100 had impaired cognition, required extensive assistance of two with bed mobility and transfers. Resident # 100 had one stage 1 (red area) pressure area. The CAAs [Care Area Assessment], dated 8/2/11, indicated "...pressure ulcer- 8/2/11 right lower extremity 0.8 x [by] 1.1 x 0.0 cm. 100% epithelialization; pressure r/t [related to] use of knee immobilizer...."</p> <p>A Skin At Risk Assessment, dated</p>				<p>to verify placement of preventative skin care items Education will be provided to nursing staff regarding:</p> <ul style="list-style-type: none"> Review of the facility's skin care policy and procedure The new system for C.N.A.s to visualize the skin of all residents during the am care and alerting the nurse to any new concern Notification of the Unit Manager or designee of any new skin concern for immediate intervention and communication to the C.N.As regarding the new intervention Skin checks every shift under any immobilizing device as allowed by the physician Rounds for Charge Nurses with the C.N.A.s to visualize placement of preventative skin care <p>IV. The DON and/or designee will audit:</p> <ul style="list-style-type: none"> daily skin visualization by the C.N.A.s during am care and follow up by the nurse with any concerns; immediate notification of the UM with any new skin concerns and implementation of new interventions Review of all new admissions, residents with an immobilizer type device, and any residents with a pressure ulcer at the facility's At Risk Meeting for the need for new interventions. Skin checks completed below any immobilizer device every shift or as allowed by the physician Every shift rounds between Charge Nurse and C.N.A. to verify placement of preventative skin care item <p>The</p>		

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	<p>7/26/11, indicated "Risk factors- Impaired mobility, and or decreased functional ability (cast or splint), potential for increase in friction and shear, cognitive impairment and exposure of skin to urinary and or fecal incontinence...At Risk? Yes..."</p> <p>The Skin inspection tool, dated 7/26/11, indicated "...skin intact, no redness..."</p> <p>A Physician order, dated 7/26/11, indicated "Daily skin check under immobilizer."</p> <p>A Care plan, dated, 07/26/2011, indicated a problem of "Resident is at risk for skin breakdown R/T [related to] dementia, femur fracture, decreased mobility, poor PO intake and anemia. The approaches were "09/06/2011, Up for meals only. To be positioned from side to side with pillows between legs. Not to be placed supine or upon abdomen. Float dependent heel when turned side-to-side. 07/26/2011, Conduct a systematic skin inspection weekly. Pay particular attention to the bony prominence's. 07/26/2011, Encourage physical activity, mobility, and range of motion to maximal potential. 07/26/2011, Float heels to relieve pressure on the heels. 07/26/2011, Keep clean and dry as possible. Minimize skin exposure to moisture. 07/26/2011, Keep linen</p>				<p>results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Completion Date: September 23, 2011 <u>We respectfully request re-visit be scheduled as soon as possible following approval of the POC.</u></p>		

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	<p>clean, dry, and wrinkle free. 07/26/2011, Report any signs of skin breakdown (sore, tender, red, or broken areas). 07/26/2011, Turn and reposition every 2 hours and prn."</p> <p>A Physician order, dated 8/1/11, indicated "Monitor skin pressure points from brace R [right] leg qd [everyday]."</p> <p>The Nurses Notes, dated 08/15/2011 at 14:43 (2:43 P.M.), indicated " N/O [new order]: 1) Continue non-wt. [weight] bearing RLE [right lower extremity]; 2) Keep knee immobilizer on at all times except for checking skin daily; 3) Follow-up 4-5 wks [weeks] for repeat X-rays."</p> <p>The Nurses Notes, dated 08/22/2011 23:45 (11:45 P.M.), indicated "5 cm dark area noted to rt [right] heel. N.O.[new order] elevate heels when in bed, apply skin prep to Rt heel Q [every] shift."</p> <p>A Care plan, dated 08/22/2011, indicated a problem of "Discolored area to right heel - resident has poor PO [by mouth] intake and anemia." The approaches were "08/27/2011 Pillow to broda chair pedal to elevate right foot and decrease pressure on heel. Turn side to side in bed with pillow between legs."</p>						

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	<p>A skin inspection tool, dated 8/24/11, indicated "Top of L [left] foot with scratch marks ? toenails will have podiatrist see him. small areas inner buttocks less red. Dark area rt [right] heel firm. L [left] heel pink..."</p> <p>The Nurses Notes, dated 08/27/2011 16:14 (4:14 P.M.), indicated "Multipodous boot is being used to Right foot."</p> <p>A skin inspection tool, with no date or signature, located between the 8/24/11 note and the 9/1/11 note, indicated "Red areas inner buttocks area rt heel firm."</p> <p>A skin inspection tool, dated 9/1/11, indicated "R heel eschar, buttocks redness..."</p> <p>The Nurses Notes, dated 09/01/2011 14:58 (2:58 P.M.), indicated "left upper arm wound resolved. right heel 100% necrotic tissue no drainage or pain. will continue current tx [treatment] as ordered to right heel..."</p> <p>A Skin Inspection Tool, dated 9/3/11, indicated "1. 2 cm x 1 cm to R lateral calf. 2. 5 cm x 5 cm to R distal calf. 3. 2 cm x 2 cm to R inner ankle. All areas are intact, reddish brown areas. Allevyn foam drsgs [dressings] applied."</p>						

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	<p>The Nurses Notes, dated 09/03/20 12:48 (12:48 P.M.), indicated "Area to R outer calf 2cm x 1cm, R inner ankle 5cm x 5cm, R Achilles 2cm x 2cm. All areas a reddened-brown (sic) color, c/d/i [clean/dry/intact]. Covered with allevyn as ordered."</p> <p>A Physician order, dated 9/3/11 at 2:00 P.M., indicated "Dx [diagnosis]: Pressure areas. Apply allevyn foam drsgs [dressings] to pressure areas on 1. R later (sic) calf. 2. R distal calf. 3. R inner ankle. Change every 3 days."</p> <p>A Care plan, dated 09/03/2011, indicated a problem of "Resident has an open area to right calf and ankle." The approaches were "09/08/2011, Use blue soft boot to relieve pressure alternate to float heels in bed. Boot is to be off when up in padded broda chair. 09/03/2011, Assess the ulcer for location, size (length, width, and depth), presence/absence of granulation tissue and epithelization weekly. 09/03/2011, Conduct a skin inspection weekly. 09/03/2011, Keep bony prominences from direct contact with one another with: use pillow between legs when in bed. 09/03/2011, Treatment to areas per orders. 09/03/2011, Turn and reposition every bedcheck."</p> <p>The Nurses Notes, dated 09/04/2011</p>						

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	<p>12:51 (12:51 P.M.), indicated "Allevyn foam drsgs c/d/i to skin areas on RLE."</p> <p>The Nurses Notes, dated 09/06/2011 10:39 (10:39 A.M.), indicated "IDT intervention changed to up for meals only, turn side to side and do not place supine or prone."</p> <p>The Nurses Notes, dated 09/06/2011 15:57 (1:57 P.M.), indicated "New order received from (name) NP [nurse practitioner] to treat OA [open area] with santyl allevyn foam nonadherent (sic) dressing to be changed daily. To be up for meals only, turned side to side with pillow between legs, not to be placed supine or on back. Dr. (name) office was called concerning brace. Awaiting further orders."</p> <p>The Nurses Notes, dated 09/07/2011 13:53 (1:53 P.M.), indicated "New orders received: D/C immobilizer... Pt [patient] to remain NWB [nonweight bearing] to RLE [right lower extremity]..."</p> <p>The Nurses Notes, dated 09/07/2011 16:18 (4:18 P.M.), indicated "Dr (name) called and discontinued knee immobilizer on right leg. Boot also discontinued at this time."</p> <p>The Nurses Notes, dated 09/08/2011</p>						

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	<p>11:36 (11:36 A.M.), indicated "Skin preped (sic) intact brown area to R calf. Did tx for R Achilles and heel, both wounds were intact and black in color."</p> <p>The Nurses Notes, dated 09/08/2011 16:55 (4:55 P.M.), indicated "Upon weekly evaluation to right heel, measurements and appearance shows signs of improvement. (name) NP was notified. Current TX remains in place. Family was notified."</p> <p>The Nurses Notes, dated 09/09/2011 13:53 (1:53 P.M.), indicated "After assessment of client's skin N.O. received per Dr. (name): Clarification: D/C heelz up, Soft boot on foot that is laying against bed when turned side to side. Boot is to be on only while in bed. Family is aware of this."</p> <p>A Weekly Wound Evaluation Flow Record, dated 8/22/11, indicated "...Site/Location: Rt heel. Date of Onset: 8-22-11. Pressure Ulcer. Acquired: in-house...4.2 x 3 cm, ? depth. Color: black...Current Tx: skin prep to R heel q shift...Date 9-1-11. Eschar...4.8 x 3.2...color black...current tx: skin prep; float heals (sic) 100% necrotic. Response to tx: no change...Date 9/7/11. Stage-eschar...6 cm x 4.1 cm...cont [continue] with current tx. Response to tx:</p>						

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	<p>improved."</p> <p>A Weekly Wound Evaluation Flow Record, dated 9/3/11, indicated "Date 9/3/11. Stage II [two]. R outer calf. Size 2 cm x 1 cm. Depth none...Current Tx: Allevyn foam change Q 3 days...Date 9/7/11. Stage II...1.3 x 2 cm...Black...80% eschar. Current tx: Allevyn foam change every 3 days."</p> <p>A Weekly Wound Evaluation Flow Record, dated 9/3/11, indicated "Date 9/3/11. Stage II. R inner ankle. 5 cm x 5 cm. Depth none...Date 9/7/11. Stage II...1.5 cm x 1 cm..."</p> <p>A Weekly Wound Evaluation Flow Record, dated 9/3/11, indicated "Date 9/3/11. Stage I [one]. R Achilles. 2 cm x 2 cm. Depth none...Current Tx: Allevyn change...Date 9/7/11. Stage III [three]...6.8 x 3.5 cm. Depth 0.1 cm...Current tx: santyl, cover with allevyn foam every day. 100% slough..."</p> <p>A Weekly Wound Evaluation Flow Record, dated 9/12/11, "Site: R outer ankle. Date of Onset: 9/12/11. Pressure Ulcer. Acquired in house...Stage II 1.0 cm diameter...Current Tx: skin prep..."</p> <p>This federal deficiency was cited on 7/27/11. The facility failed to implement a systemic plan of correction to prevent</p>						

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